DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|-----|---|------------|----------------------------|
| | | 445378 | B. WING | | | 12/01/2020 | |
| NAME OF PROVIDER OR SUPPLIER WOODCREST AT BLAKEFORD | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 BURTON HILLS BLVD NASHVILLE, TN 37215 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | was conducted by S The facility was fou CFR §483.80 infect has implemented th Disease Control and recommended pract COVID-19. Total ce | sed Infection Control Survey State Agency on 12/1/2020. Indition to be in compliance with 42 ion control regulations and the CMS and Centers for d Prevention (CDC) | | 000 | TITLE | | (X6) DATE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| E 000 | Survey was conduct 12/1/2020. The faci | sed Emergency Preparedness sted by the State Agency on lity was found to be in CFR §483.73 related to | E 00 | | | |
| ARORATORY | DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | JATURE | TITLE | | (X6) DATE |

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program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A, BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--|--|-------------------------------|------|--|
| , | | | A. BUILDING. | | | | |
| TN1932 | | TN1932 | B. WING | | 12/01/2020 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| WOODCREST AT BLAKEFORD 11 BURTON HILLS BLVD NASHVILLE, TN 37215 | | | | | | | |
| | CLIMANADV CTA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION | ON | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | COMPLETE DATE | | |
| N 000 | N 000 Initial Comments A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 12/1/2020. The facility was found to be in compliance under Chapter 1200-8-6, Standards for Nursing Homes, infection control regulations and has implemented the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 42. | | N 000 | | | | |
| | | | | | | | |
| | | | | | | | |

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE